Iowa Plan for Behavioral Health

Performance Indicators

July 1, 2010 to June 30, 2011

June 2011 Report

PERFORMANCE INDICATORS
CARRYING MEDICAID FINANCIAL INCENTIVES
IOWA PLAN FOR BEHAVIORAL HEALTH
July 1, 2010 – June 30, 2011

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which financial incentives have been attached. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurements (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75th and 90th percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

The Contractor shall be paid the amount the Department of Human Services has associated with each indicator. The Department of Human Services shall be solely responsible for determining whether or not the Contractor has met the required level of performance. The Department shall take whatever steps it deems appropriate to validate all information provided by the Contractor, including auditing Contactor measurement processes and data, prior to issuing incentive payments.

1. Quality of Care: Mental Health Readmission

Rate of mental health inpatient readmission by children and adults at 7, 30, and 90 days.

Numerator: the number of inpatient readmissions within 7/30/90 days of discharge*
Denominator: the number of inpatient discharges that occur within the reporting periods, less 7/30/90 days*

*Discharges/readmits at the MHIs where the Enrollee is moving between inpatient and residential are not counted. Court-ordered inpatient admissions are not counted.

Data source: claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
7-day readmission												
Children	5.7%	2.6%	3.1%	3.4%	4.9%	3.1%	3.4%	1.4%	3.4%	4.7%	2.0%	5.3%
Adults	4.5%	2.3%	3.8%	3.6%	5.6%	7.1%	5.8%	2.5%	2.5%	1.4%	3.0%	4.1%
Overall	4.8%	2.4%	3.6%	3.5%	5.4%	5.5%	5.0%	2.1%	2.9%	2.6%	2.6%	4.5%
30-day readmission												
Children	10.5%	13.5%	7.4%	10.4%	8.6%	15.3%	8.6%	12.4%	13.0%	10.5%	12.9%	12.8%
Adults	13.8%	11.5%	8.4%	15.5%	12.2%	13.5%	17.0%	13.2%	10.0%	11.0%	12.4%	12.3%
Overall	12.8%	12.0%	8.1%	13.6%	11.0%	14.1%	13.8%	13.0%	11.0%	10.8%	12.6%	12.5%
90-day readmission												
Children	14.8%	21.7%	21.9%	20.2%	20.0%	17.9%	17.5%	19.4%	16.1%	20.5%	18.5%	19.7%
Adults	23.9%	20.0%	21.7%	18.0%	18.2%	27.0%	20.6%	25.1%	24.7%	23.7%	18.8%	20.1%
Overall	20.8%	20.6%	21.8%	18.6%	18.8%	23.6%	19.6%	23.0%	21.4%	22.7%	18.7%	19.9%

	7-day readmission	**30-day readmission**	**90-day readmission**
Standard	6% or less (monitor only)	14% or less (incentive)	25% or less (monitor only)
Contract Period to Date	Children: 3.7% Adults: 3.9% Overall: 3.9%	Children: 11.7% Adults: 12.6% **Overall: 12.3%**	Children: 19.1% Adults: 21.9% Overall: 21.0%

2. Quality of Care: Community Tenure

The average time between mental health hospitalizations per contract period shall not fall below 94 days for Iowa Plan Enrollees.

For Enrollees who were admitted to a mental health inpatient hospital setting which is funded by the Contractor and subsequently readmitted to a mental health inpatient hospital setting funded by the Contractor within the contract period and the preceding 12 months of the contract period, the average number of days between discharge and readmission(s). The numbers must reflect all Enrollees who were re-admitted despite Contractor denial as well as those Enrollees whose admission was authorized.

Data source: authorizations (calculations for tenure report the results for the 24 month period prior to and including the reporting month)

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Children	99.3	102.4	110.4	103.2	105.5	101.8	111.1	103.1	100.9	98.2	106.4	107.1
Adults	96.9	96.4	94.9	94.9	93.8	92.5	89.4	94.2	93.5	95.4	90.0	89.9
Overall	97.6	98.1	99.2	97.2	97.1	95.2	95.5	96.7	95.6	96.2	94.7	94.9

Standard	**94 days or more (children) (monitor only)** **94 days or more (adults) (monitor only)** **94 days or more (children and adults) (incentive)**

3. Service Array: Integrated Services and Supports

At least 18% of mental health service expenditures, combined for children and adults, will be used in the provision of integrated services and supports, including natural supports, consumer-run programs, and services delivered in the home of the Enrollee.

Numerator: the Contractor's combined mental health expenditures for integrated services and supports, consumer-run programs, and services delivered in the Enrollee's home, but also reported separately for adults and children

Denominator: the Contractor's total claims expenditures for mental health services, but also reported separately for adults and children (includes a prorated portion of CMHC reconciliation payments)

Data source: claims (calculations are year-to-date)

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Children	0.7%	0.8%	0.9%	0.9%	0.8%	0.9%	0.9%	1.0%	1.0%	1.0%	0.9%	1.9%
Adults	31.8%	22.8%	28.7%	26.5%	24.9%	22.5%	26.4%	26.4%	25.6%	25.4%	26.6%	20.2%
Overall	18.4%	18.6%	17.1%	16.0%	16.6%	16.4%	16.1%	16.0%	15.6%	15.5%	15.9%	13.8%

Standard	Children and adults: (monitor only) Overall: 18% or more (incentive)
Contract Period to Date	Children: 1.0% Adults: 25.1% **Overall: 15.7%**

4. Quality of Care: Follow-up Contact After Hospitalization for Mental Illness

90% of Enrollees discharged from mental health inpatient care will receive a follow-up contact by a provider or by Magellan staff within 7 days of discharge.

Numerator: the number of Enrollees discharged from a mental health inpatient setting (whether or not the inpatient hospitalization was authorized by the contractor at the time of discharge) during the contract period for whom claims data or other information from a provider reflects subsequent treatment service or a follow-up with Magellan's Staff within 7 calendar days of the discharge date

Denominator: the number of Enrollees discharged from a mental health inpatient setting (whether or not the inpatient hospitalization was authorized by the contractor at the time of discharge) during the contract period

Exclude: clients not enrolled in the Iowa Plan at the time of discharge are excluded, even those clients who later gain Iowa Plan enrollment for the month of service. Clients determined to be admitted for a non-Iowa Plan diagnosis.

Data source: authorizations, IP medical record, and claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
% d/c'd	90.0%	91.2%	89.6%	93.0%	87.5%	91.4%	91.7%	92.0%	91.1%	89.9%	90.3%	
Standard							90% or more (incentive)					
Contract Period to Date							**90.9%**					

Note: the data are internally audited each month for accuracy. Changes may result from the audits. In reporting, there is a one month lag for auditing purposes.

5. Quality of Care: Follow-up After Hospitalization for Mental Illness (modified HEDIS)

56% of Enrollees 6 years of age and older discharged from mental health inpatient care for selected disorders will receive outpatient, intensive outpatient program or partial hospitalization treatment services with a mental health practitioner within 7 days of discharge.

76% of Enrollees 6 years of age and older discharged from mental health inpatient care for selected disorders will receive outpatient, intensive outpatient program or partial hospitalization treatment services with a mental health practitioner within 30 days of discharge.

National benchmarks:

Description	Mean	P10	P25	P50	P75	P90
FUH-07D	42.6	15.5	31.6	44.5	56.6	64.2
FUH-30D	61.7	37.3	49.6	64.3	75.7	81.2

Numerator and Denominator: utilize HEDIS 2009 specifications for the measure "Follow-Up After Hospitalization for Mental Illness"

Exclude: enrollees with Medicaid and Medicare

Data source: claims and enrollment

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
% 7-Day	56.7%	56.4%	60.6%	61.0%	55.8%	59.4%	61.6%	58.2%	58.1%	60.8%	62.6%	
% 30-Day	69.2%	67.7%	70.7%	70.1%	68.9%	72.3%	74.0%	67.9%	68.4%	68.9%	69.6%	

Standard	56% or more within 7 days of discharge (incentive) 76% or more within 30 days of discharge (monitor only)
Contract Period to Date	**7-Day: 59.3%** 30-Day: 69.8%

Note: the data are claims-based and there is a one month lag for claims submission. Monthly numbers will be continuously updated as claims are submitted.

6. Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment

60% of Enrollees discharged from ASAM Levels III.5 and III.3 will receive a follow-up substance abuse service within 14 days of discharge.

Numerator: the number of Enrollees discharged from ASAM Levels III.5 and III.3 who received a follow-up substance abuse service reimbursed by the Contractor within 14 days (as documented in the Contractor's claim system) of discharge

Denominator: the number of Enrollees discharged from ASAM Levels III.5 and III.3

Exclude: Enrollees with Medicaid and Medicare

Data source: authorizations and claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
% d/c'd	89.0%	83.2%	86.3%	86.1%	80.2%	85.1%	76.1%	91.0%	93.8%	82.9%	87.9%	

Standard	60% or more within 14 days of discharge (incentive)
Contract Period to Date	**85.5%**

Note: the data are internally audited each month for accuracy. Changes may result from the audits. In reporting, there is a one month lag for auditing purposes.

7. Quality of Care: Implementation of Mental Health Inpatient Discharge Plans
94% of all discharge plans written for Enrollees being released from a mental health inpatient hospitalization shall be implemented (minimum of 240 charts).

Numerator: number of Enrollees* who have been discharged from a mental health inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge) for whom claims data or provider records reflect implementation of the follow-up plan written with the Enrollee at the time of discharge
Denominator: number of Enrollees* who have been discharged from a mental health inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge)
*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Data source: chart review

	Contract Period to Date
% with discharge plan implemented	95.6%
Number of charts with d/c plan implemented	282
Number of charts reviewed	295
Providers visited	26
Standard	94% or more of all discharge plans are implemented (incentive) Minimum of 240 charts (annual number)

8. Quality of Care: Outcome Measurement – Medicaid Children and Adolescents
The Contractor shall support Medicaid child and adolescent Enrollees such that at least 50% of children and adolescents receiving Iowa Plan outpatient services report improvement in the psychosocial domain as reported by comparison of initial and most recent assessment using the Consumer Health Inventory for Children (CHI-C).

Numerator: the total number of Enrollees, age 0-17, that have at least 2 CHI scores with the most recent during the reporting period, where improvement is shown from the first to the most recent score

Denominator: the total number of Enrollees, age 0-17, that have at least 2 CHI scores with the most recent during the reporting period

Data source: CHI-C outcomes assessment report

	2010						**2011**					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
%	47.1%	54.1%	64.4%	59.2%	61.0%	59.8%	56.6%	60.2%	63.1%	65.0%	61.1%	56.5%
Standard							At least 50% report improvement Report aggregate improvement from initial to follow up administration					
Contract Period to Date							**61.1%**					

MEDICAID PERFORMANCE INDICATORS
WITH FINANCIAL DISINCENTIVES
IOWA PLAN FOR BEHAVIORAL HEALTH
July 1, 2010 – June 30, 2011

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which financial disincentives have been attached. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurement (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75th and 90th percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

Disincentives shall be assessed solely at the discretion of the Department of Human Services. The Departments shall take whatever steps they deem appropriate to validate all information provided by the Contractor, including auditing Contactor measurement processes and data.

1. Consumer Involvement

   New Enrollee information, including a list of network providers, will be mailed to each new Enrollee in the Iowa Plan within 10 working days after the first time his or her name is provided to the Contractor.

   When the name of a new Iowa Plan Enrollee is provided to the Contractor, the Contractor shall mail required new Enrollee information on Iowa Plan services within 15 working days. The standard shall be met for 95% of Enrollees, and in no case shall more than 15 working days elapse before all new Enrollees are mailed enrollment information.

   Data source: manual tracking system

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% within 10 working days	100.0%	100.0%	100.0%	100.0%
% within 15 working days	100.0%	100.0%	100.0%	100.0%
% over 15 working days	0.0%	0.0%	0.0%	0.0%
Standard	**95% within 10 working days** **100% within 15 working days**			

2. Quality of Care: Mental Health Discharge Plan

A discharge plan shall be documented on the day of discharge for 90% of Enrollees being discharged from the following mental health settings: inpatient, partial hospitalization, and day treatment. The discharge plan shall include, at a minimum: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) if applicable, restrictions on activities and when the Enrollee can return to work or school, including the school setting.

Numerator: the number of Enrollees* who have been discharged from mental health inpatient, mental health partial hospitalization, and mental health day treatment for whom a discharge plan was documented in the record on the day of discharge

Denominator: the number of Enrollees* discharged from mental health inpatient, mental health partial hospitalization, and mental health day treatment settings

Note: this measure excludes Enrollees who left treatment against medical advice

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

Data source: retrospective chart reviews

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% with d/c plan documented	100.0%	96.7%	98.4%	100.0%
Number of charts with d/c plan documented	89	87	61	51
Number of charts reviewed	89	90	62	51
Providers visited	8	8	6	5
Contract Period to Date	% with d/c plan documented: 98.4% Number of charts with d/c plan documented: 247 Number of charts reviewed: 251 Providers visited: 23			
Standard	**90% or more with documented discharge plan at discharge**			

3. Quality of Care: Discharge to Homeless or Emergency Shelter

The percentage of Enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 1.0% of all mental health inpatient discharges of children under the age of 18.

Numerator: the number of Enrollees under the age of 18 who were transferred to a homeless or emergency shelter upon discharge from mental health inpatient care

Denominator: the number of Enrollees under the age of 18 who were discharged from mental health inpatient care

Note: Enrollees may be excluded if discharged upon the signed recommendation of a DHS or JCS worker

Data source: authorizations

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% of children	0.0%	0.0%	0.0%	0.1%
Standard	**≤1.0%**			

4. Quality of Care: Follow-up on Emergency Room visits

95% of Enrollees who received services in an emergency room shall have a follow-up contact within 3 business days of the date the Contractor is notified of the ER service.

Numerator: the number of Enrollees who were served in an emergency room, who received a documented follow-up contact within 3 business days of the date the Contractor was notified of the emergency room service.

Denominator: the number of Enrollees who were served in an emergency room and the Contractor was notified of the emergency room service.

Note: documented follow-up may include treatment at a 24-hour setting to which the Member returned or was admitted following the ER presentation. In addition, documented follow-up includes Contractor's attempt to reach the Enrollee telephonically for each 24-hour period up to 3 business days and a subsequent letter to the Member within 3 business days if the Enrollee could not be reached telephonically.

Data source: ER tracking system

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% follow-up	99.4%	99.8%	99.9%	99.7%
Standard	**95% or more**			

5. Quality of Care: Participation in Joint Treatment Planning Conferences

The Contractor shall arrange or participate in at least 20 Joint Treatment Planning conferences per month, and 450 per year.

The number of times during the contract period in which staff representing the Contractor participated in prescheduled conference calls or face-to-face meetings in which persons authorized to commit funds from at least one other funding stream worked w/or on behalf of an Enrollee to design or revise a treatment plan.

Data source: JTP tracking system

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
# of JTPCs	71	62	77	80	74	56	94	123	101	78	88	70
Contract Period to Date	974 JTP conferences conducted											
Standard	**20 JTPCs per month and 450 or more per year**											

6. Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment

At least 63% of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House) receive a follow-up substance abuse service within 30 days of discharge. Enrollees that left treatment AMA are excluded.

Numerator: the number of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House) who received a follow-up substance abuse service reimbursed by the Contractor within 30 days of discharge (as documented in the Contractor's claim system). Enrollees that left treatment AMA are excluded.

Denominator: the number of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House). Enrollees that left treatment AMA are excluded.

Exclude: Enrollees who leave against medical advice (AMA)

Data source: authorizations and claims

	2010		2011	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% follow-up	79.7%	79.7%	77.3%	74.8%
Standard	**63% or more**			

Note: the data are internally audited each month for accuracy. Changes may result from the audits. In reporting, there is a one month lag for auditing purposes.

7. Quality of Care: Substance Abuse Treatment Discharge Plan

A discharge plan shall be documented on the day of discharge for 90% of Enrollees being discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting.

Numerator: the number of Enrollees* who have been discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting for whom a discharge plan was documented in the record on the day of discharge

Denominator: the number of Enrollees* discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting

Note: this measurement excludes Enrollees who left treatment against medical advice. This measure may be done based on a random sample of record audits.

*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period

Data source: retrospective chart reviews

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% with d/c plan documented	100.0%	100.0%	100%	100%
Number of charts with d/c plan documented	17	22	8	28
Number of charts reviewed	17	22	8	28
Providers visited	3	4	2	7
Contract Period to Date	% with d/c plan documented: 100.0% Number of charts with d/c plan documented: 75 Number of charts reviewed: 75 Providers visited: 16			
Standard	**90% or more**			

8. Claims Payment

Medicaid claims shall be paid or denied within the following time periods:

- 90% within 12 calendar days;
- 99% within 30 calendar days;
- 100% within 90 calendar days.

Times shall be calculated from the date the claim is received by the Contractor until the date the check or denial letter is mailed to the provider.

Data source: claims

	2010		2011	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% within 12 days	99.71%	99.60%	99.67%	98.25%
% within 30 days	99.98%	100.00%	100.00%	100.00%
% within 90 days	100.00%	100.00%	100.00%	100.00%
% over 90 days	0.00%	0.00%	0.00%	0.00%
Standard	**90% within 12 calendar days 99% within 30 calendar days 100% within 90 calendar days**			

9. Appeal Reviews

95% of appeals will be resolved as expeditiously as the Enrollee's health condition requires and within 14 calendar days from the date the Contractor received the appeal, other than in instances in which the Enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.

In the event of an extension, 95% of the time the Contractor shall resolve the appeal within the additional 14-calendar-day period, and, in the case of a DHS-approved extension, give the Enrollee written notice of the reason for the decision to extend the timeframe.

Data source: appeal tracking system

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% resolved within 14 days	99.0%	98.1%	99.4%	99.1%
% of extended resolved within 14 days	no ext.	no ext.	no ext.	no ext.
% resolved within 45 days	100.0%	100.0%	100.0%	100.0%
Contract Period to Date	98.9% resolved within 14 days 100.0% resolved within 45 days			
Standard	**95% appeals resolved within 14 calendar days 100% appeals resolved within 45 calendar days 95% of ext. reviews resolved within 14 calendar days from the end of the initial 14-day period**			

10. Expedited Appeal Reviews

100% of expedited appeals will be resolved as expeditiously as the Enrollee's health condition requires and within 72 hours from the date the Contractor received the appeal, other than in instances in which the Enrollee has requested, or DHS has approved, an extension.

In the event of an extension, 95% of the time the Contractor shall resolve the appeal within 14 calendar days from the end of the 24-hour period, and, in the case of a DHS-approved extension, give the Enrollee written notice of the reason for the decision to extend the timeframe.

Data source: appeal tracking system

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% resolved within 72 hours	100.0%	100.0%	100.0%	100.0%
% of extended reviews resolved within 14 days	no ext.	no ext.	no ext.	no ext.
Contract Period to Date	100.0% resolved within 72 hours			
Standard	**100% appeals resolved within 72 hours of receipt 95% of extended reviews resolved within 14 calendar days from the end of the 24-hour period**			

11. Grievance Reviews

95% of grievances will be resolved as expeditiously as the Enrollee's health condition requires and within 14 days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 60 calendar days of the receipt of all required documentation.

Data source: grievance tracking system

	2010		2011	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% resolved within 14 days	100.0%	100.0%	100.0%	100.0%
% resolved within 60 days	100.0%	100.0%	100.0%	100.0%
Contract Period to Date	100.0% resolved within 14 days			
Standard	**95% resolved within 14 days 100% resolved within 60 days**			

12. Network Management

Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 60% within 30 days; 100% within 90 days.

Completion time shall be tracked from the time all required paperwork is provided to the Contractor until the time a written communication is mailed or faxed to the provider notifying them of the Contractor's determination.

Data source: credentialing tracking system

	2010		2011	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% within 30 days	89.3%	100.0%	94.4%	96.7%
% within 90 days	100.0%	100.0%	100.0%	100.0%
% over 90 days	0.0%	0.0%	0.0%	0.0%
Standard	**60% credentialed within 30 days, 100% within 90 days**			

13. Network Management

Revisions to the Provider Manual shall be distributed to all network providers at least 30 calendar days prior to the effective date of the revisions.

Mailing dates of provider manual material shall be sent at least 30 calendar days prior to the effective date of material contained in the mailing. This measure applies to all information sent for all network providers.

Note: with approval from the Departments, the time period preceding the effective date of a change may be less than 30 days if the change confers a benefit on providers or those served through the Iowa Plan.

Data source: manual

Progress to Date	• No revisions to the provider manual in July 2010. • No revisions to the provider manual in August 2010. • No revisions to the provider manual in September 2010. • No revisions to the provider manual in October 2010. • No revisions to the provider manual in November 2010. • No revisions to the provider manual in December 2010. • No revisions to the provider manual in January 2011. • No revisions to the provider manual in February 2011. • No revisions to the provider manual in March 2011. • No revisions to the provider manual in April 2011. • No revisions to the provider manual in May 2011. • A BHIS section added to appendix B. Notification was sent June 1. The effective date was July 1.
Standard	**Distributed 30 days or more prior to effective date**

IDPH PERFORMANCE INDICATORS
CARRYING LIQUIDATED DAMAGES
IOWA PLAN FOR BEHAVIORAL HEALTH
July 1, 2010 – June 30, 2011

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which disincentives have been attached. These indicators will be reassessed annually by IDPH and the Iowa Plan Advisory Committee and may be modified annually at IDPH's discretion. Each indicator should be reported with either monthly or quarterly measures (as specified) and with a contract year-to-date measure.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

The Contractor shall be paid the amount the Department of Public Health has associated with each indicator. The Department of Public Health shall be solely responsible for determining whether or not the Contractor has met the required level of performance. IDPH shall validate all information provided by the Contractor prior to issuing incentive payments.

Indicators ##1, 4, 5, and 6 will be updated during the next reporting period after the data are received from the IDPH.

1. Minimum Number Served The Contractor shall at least serve the minimum number of unduplicated IDPH Participants. Methodology: number of unduplicated IDPH Participants in accordance with contract condition with IDPH source of payment Data source: Iowa Service Management and Report Tool (I-SMART)	
Progress to Date	22,444
Standard	**Minimum unduplicated number of IDPH Participants: 19,154**

2. Use of Service Necessity Criteria

90% of all retrospectively reviewed records for IDPH Participants will document the appropriate use of ASAM PPC2-R or the PMIC Admission and Continued Stay criteria, whichever is applicable, by network providers.

Data are updated quarterly.

Date source: provider records

	2010		2011	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% with appropriate use documented	100.0%	100.0%	94.7%	100.0%
Number of charts with appropriate use documented	16	22	18	30
Number of charts reviewed	16	22	19	30
Providers visited	2	4	5	4
Contract Period to Date	% with appropriate use documented: 98.9% Number of charts with appropriate use documented: 86 Number of charts reviewed: 87 Providers visited: 15			
Standard	**90% or more**			

3. Network Development

Incentive funding performance measures for the IDPH Participant provider network will be determined by December 31, 2010 following meetings involving providers, IDPH, and Magellan. Magellan will distribute incentive funding performance pilot project reports to providers between January and June 2011. Final incentive funding performance measures will be a part of the IDPH Provider Agreement beginning July 1, 2011.

Date source: minutes of meetings; provider agreements

Contract Period to Date	Incentive methodology developed at meetings on September 9, September 30, October 21, November 16. Final methodology approved at meeting December 16th. Baseline results sent to providers on April 22, 2011.
Standard	**Performance measure identified**

4. Timely Receipt of Care

90% of IDPH Participants who request and are in need of treatment for IV drug abuse are admitted to the IV drug treatment program not later than 14 days after making the request for admission, or 120 days after the date of the request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.

Numerator: the number of IDPH Participants who request and are in need of IV drug abuse treatment and who receive treatment within 14 days of making the request *when program capacity exists at the time of the request*

Denominator: the number of IDPH Participants who request and are in need of IV drug abuse treatment *when program capacity exists at the time of the request*

Numerator: the number of IDPH Participants who request and are in need of IV drug abuse treatment and who receive treatment within 120 days of making the request *when program capacity does not exist at the time of the request*

Denominator: the number of IDPH Participants who request and are in need of IV drug abuse treatment *when program capacity does not exist at the time of the request*

Data source: provider records

	2010		**2011**	
	Quarter to Date (Jul-Sep)	**Quarter to Date (Oct-Dec)**	**Quarter to Date (Jan-Mar)**	**Quarter to Date (Apr-Jun)**
% within 14 days of request if capacity exists	90.6%	88.1%	82.0%	81.1%
% within 120 days if capacity does not exist	100.0%	100.0%	100.0%	100.0%
Standard	**90% or more within 14 days (capacity exists)** **90% or more within 120 days (capacity does not exist)**			

5. Client Mix

The Contractor shall maintain the appropriate percentages of IDPH Participant client mix.

Methodology: percent of IDPH Participants in accordance with contract conditions with IDPH source of payment

Data source: I-SMART

	Contract Period to Date (Monitor Only)	Standard
Women	26.2%	**27.8%**
Pregnant	1.9%	**4.3%**
Criminal justice referral source	47.5%	**63.9%**
Unemployed	40.7%	**30.7%**
Prior substance abuse treatment	54.3%	**41.3%**
Race other than white	13.7%	**12.5%**
Monthly taxable income under $1,000	73.1%	**65.0%**

6. Wait Time

The Contractor shall ensure that 75% of IDPH Participants recommended for and admitted to an Iowa Plan level of care are admitted within 5 calendar days of the assessment date.

Data source: I-SMART

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
% within 5 days	97.7%	97.6%	97.3%	95.7%	96.2%	96.0%	95.8%	96.8%	96.0%	98.2%	96.7%	99.3%
Contract Period to Date	96.9%											
Standard	**75% or more**											

PERFORMANCE INDICATORS MONITORING ONLY
IOWA PLAN FOR BEHAVIORAL HEALTH
July 1, 2010 – June 30, 2011

The Contractor shall provide to the Departments a monthly written report on all monitoring-only performance indicators. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurements (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75th and 90th percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

Consumer Involvement and Quality of Life

1. The Contractor shall conduct an annual Iowa Plan Eligible Person experience of care survey that assesses experience of care with mental health and substance abuse services for both child and adult populations. • The survey instruments shall be standardized, validated tools approved by the Departments and shall address areas recommended by the Recovery Advisory Committee. • The number of surveys distributed shall represent at least the minimum number required to comprise a statistically valid sample of those Iowa Plan Eligible Persons who have accessed services in the past six months. • The acceptable response rate shall be determined by DHS and IDPH, in consultation with the Contractor. • Results shall be reported to Iowa Plan Eligible Persons as well as corrective actions implemented in response to findings of the surveys.	
Progress to Date	Survey was mailed out in November 2010 and results were available in January 2011. Survey was mailed out in May 2011 and results are expected in July 2011.
Standard	**Consumer Surveys conducted twice per contract year and results reported**

2. Based on the annual Eligible Person experience of care survey, 85% of respondents indicate satisfaction with services provided by the Iowa Plan.	
Progress to Date	Survey was mailed out in November 2010. Survey results: adolescents – 86.0%, adults – 89.4%. Survey was mailed out in May 2011 and results are expected in July 2011.
Standard	**85% or more**

Access and Array

3. The number of Iowa Plan Enrollee reported overall and separately for children and adults, for whom integrated services, rehabilitation, or support services were provided during the month, shall be 1% or more.

Data source: paid claims data

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Children	140	131	163	145	182	200	183	194	273	291		
Adults	10,014	10,237	9,898	9,873	9,803	9,822	9,765	9,693	10,809	10,120		
Overall	10,154	10,368	10,061	10,018	9,985	10,022	9,948	9,887	11,082	10,411		
# eligible	387,252	389,944	390,463	391,998	392,524	393,257	395,168	395,749	397,641	398,472		
Overall %	2.6%	2.7%	2.6%	2.6%	2.5%	2.6%	2.5%	2.5%	2.8%	2.6%		
Standard					**1% or more**							

Note: a two-month claims lag is required for this report. For children, the primary service in this report is "wrap-around"; most rehabilitation and support services for children are paid for with Title XIX rehabilitation funding through the child welfare system. This accounts for the vast discrepancy in the numbers for adults and children.

4. The Contractor shall demonstrate compliance with the following access standards: Enrollees with emergency needs within 15 minutes of presentation or telephone contact with Contractor or provider; Enrollees with urgent, non-emergency needs seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with Contractor or provider; Enrollees with persistent symptoms within 48 hours of reporting symptoms; Enrollees with the need for routine services within 4 weeks of the request for an appointment. (Reported quarterly as YTD)

	2010		2011	
	Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**
# of facilites contacted	52	101	158	53
% of facilities that complied with **Emergency** standards	100.0%	100.0%	100.0%	90.6%
% of facilities that complied with **Urgent** standards	100.0%	100.0%	100.0%	100.0%
% of facilities that complied with **Persistent Symptoms** standards	100.0%	100.0%	100.0%	100.0%
% of facilities that complied with **Routine Svcs** standards	100.0%	100.0%	100.0%	100.0%
Standard	**Emergency: within 15 minutes of presentation or telephone contact** **Urgent: within 1 hour of presentation or within 24 hours of telephone contact** **Persistent Symptoms: within 48 hours of reporting symptoms** **Routine Services: within 4 weeks of request for appointment**			

5. The Contractor shall demonstrate compliance with geographical standards of access (urban—inpatient (IP) 30 minutes; outpatient (OP) 30 minutes. Rural--inpatient 45 minutes; outpatient 30 minutes).

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Urban IP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urban OP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Rural IP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Rural OP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Standard					**<u>Urban</u>: Inpatient 30 minutes; Outpatient 30 minutes <u>Rural</u>: Inpatient 45 minutes; Outpatient 30 minutes**							

6. The Contractor shall provide services to at least 16.0% of Iowa Plan Enrollees annually, reporting the unduplicated number and the percentage of Enrollees in the Iowa Plan receiving services.

   Numerator: the unduplicated number of Enrollees receiving at least once service reimbursed by the Contractor

   Denominator: unduplicated number of Enrollees

   - Also report using the following stratifications:
     - Ages 0-12, 13-17, 18-64 and 65 and older

   Data source: claims and enrollment

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
0-12	2.6%	4.2%	5.5%	6.7%	7.4%	7.9%	8.5%	8.9%	9.2%	9.6%	9.9%	10.2%
13-17	8.9%	14.6%	18.9%	22.5%	24.2%	25.5%	27.2%	28.1%	28.7%	29.8%	30.4%	30.7%
18-64	7.0%	11.0%	13.1%	14.7%	15.6%	16.2%	17.0%	17.5%	17.8%	18.4%	18.8%	19.2%
<65	6.8%	9.2%	10.8%	11.9%	12.7%	13.2%	13.5%	14.1%	14.5%	15.1%	15.5%	15.8%
65+	0.2%	0.4%	0.5%	0.7%	0.8%	0.9%	1.0%	1.0%	1.1%	1.2%	1.2%	1.3%
Overall	4.4%	7.1%	8.9%	10.5%	11.3%	11.9%	12.7%	13.2%	13.6%	14.1%	14.5%	14.8%
Standard					**16.0% or more (monitor only)**							

Appropriateness

7. The average length of stay for Enrollee mental health inpatient services for any given month shall not exceed the ALOS previously under FFS (12.0 days) and shall not fall below 5.0 days for acute services unless explicitly agreed upon by the Departments with the Contractor.

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Inpatient	5.0	4.9	4.6	5.0	4.8	4.9	4.9	5.0	5.1	4.7	4.7	4.9
Subacute	3.0	2.3	4.8	7.1	9.5	5.1	6.9	19.6	8.4	10.2	3.1	7.5
Standard	**ALOS less than 12 days, but not less than 5 days**											

Provider Satisfaction

8. The Contractor shall conduct an annual provider survey in which at least 80% of responding network providers indicate satisfaction, and shall report key findings to the Departments, including identified opportunities for improvement.

Progress to date	Survey was mailed out in January-February 2011: 91.6% of providers indicate satisfaction.
Standard	**80% or more providers satisfied**

9. <u>Quality of Care: Involuntary Hospitalization</u>

The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 10% of all child admissions and 5% of all adult admissions.

Numerator: the number of Enrollees involuntarily admitted for mental health treatment to all inpatient settings regardless of whether the Contractor authorized or is funding the hospitalization, broken out by children (ages 0-17), and adults (ages 18+)

Denominator: the number of Enrollees admitted for mental health treatment to all inpatient settings regardless of whether the Contractor is authorizing or is funding the hospitalization

Data source: authorizations

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Children	1.5%	0.0%	0.8%	0.8%	1.6%	0.9%	2.0%	1.4%	0.4%	1.3%	0.7%	
Adults	0.6%	3.3%	1.2%	2.0%	1.3%	1.1%	1.8%	1.5%	1.6%	2.2%	1.2%	
Overall	0.8%	2.4%	1.0%	1.6%	1.4%	1.0%	1.8%	1.5%	1.2%	1.9%	1.0%	
Contract period to date	Children: 1.0% Adults: 1.6% Overall: 1.4%											
Standard	**≤10% child admissions** **≤5% adult admissions**											

10. Quality of Care: Inpatient Substance Abuse Treatment Readmission

Rate of substance abuse inpatient readmission by Enrollee children and adults at 7, 30, and 90 days will be no higher than the following:
7-day readmission: children 3.5%; adults 5%;
30-day readmission: children 9%; adults 13%;
90-day readmission: children: 17%; adults 24%.

Numerator: the number of Iowa Plan Enrollee inpatient readmissions within 7/30/90 days of discharge

Denominator: the number of Iowa Plan Enrollee inpatient discharges that occur within the reporting periods, less 30 days

Data source: claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
7-day readmission												
Children	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Adults	0.0%	0.0%	0.0%	0.0%	0.0%	3.3%	8.0%	0.0%	2.9%	0.0%	3.1%	5.6%
Overall	0.0%	0.0%	0.0%	0.0%	0.0%	3.2%	8.0%	0.0%	2.9%	0.0%	3.1%	5.4%
30-day readmission												
Children	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Adults	12.0%	3.5%	0.0%	6.7%	8.0%	0.0%	10.3%	21.7%	0.0%	5.4%	9.3%	17.2%
Overall	11.1%	3.3%	0.0%	6.3%	8.0%	0.0%	10.0%	21.7%	0.0%	5.4%	8.9%	17.2%
90-day readmission												
Children	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Adults	10.5%	16.7%	16.7%	3.3%	10.3%	10.0%	12.5%	0.0%	14.3%	25.0%	15.0%	13.5%
Overall	10.0%	16.7%	15.4%	3.2%	10.0%	9.4%	12.5%	0.0%	13.8%	25.0%	15.0%	13.5%

	7-day readmission	**30-day readmission**	**90-day readmission**
Contract Period to Date	Children: 0.0% Adults: 2.0% Overall: 1.9%	Children: 0.0% Adults: 7.8% Overall: 7.6%	Children: 0.0% Adults: 12.3% Overall: 11.9%
Standard	**Children: 3.5% Adults: 5%**	**Children: 9% Adults: 13%**	**Children: 17% Adults: 24%**

11. Quality of Care: Readmission for Non-Inpatient Services

Rate of readmission by Iowa Plan eligible children and adults at 7, 30, and 90 days substance abuse residential III.3 and III.5 for which there are at least 30 discharges per month.

Numerator: the number of substance abuse residential readmissions within 7/30/90 days of discharge

Denominator: the number of discharges that occur within the reporting periods, less 7, 30, and 90 days

Data source: claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
7-day readmission												
Children	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adults	9.0%	4.4%	7.3%	4.4%	8.1%	8.8%	9.8%	9.6%	9.7%	5.3%	7.4%	12.0%
Overall	8.0%	5.7%	6.7%	3.9%	7.1%	7.6%	9.2%	8.4%	10.0%	5.8%	6.5%	10.8%
30-day readmission												
Children	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Adults	8.6%	10.6%	8.3%	6.2%	4.1%	13.6%	22.7%	10.9%	15.2%	8.7%	7.5%	17.1%
Overall	8.9%	9.0%	9.0%	6.8%	3.5%	12.1%	19.2%	10.3%	13.1%	8.9%	6.6%	14.9%
90-day readmission												
Children	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	21.1%
Adults	12.5%	16.7%	11.2%	18.2%	16.7%	10.0%	10.8%	20.3%	23.1%	16.4%	19.4%	10.6%
Overall	12.6%	15.1%	12.4%	16.4%	16.4%	10.3%	9.5%	18.2%	20.5%	15.5%	16.5%	12.4%

	7-day readmission	**30-day readmission**	**90-day readmission**
Contract Period to Date	Children: 5.1% Adults: 9.8% Overall: 9.3%	Children: 7.1% Adults: 12.4% Overall: 11.8%	Children: 8.0% Adults: 15.8% Overall: 14.9%

Note: N/A is indicated when less than 30 discharges occurred during the reporting period. The YTD number typically exceeds 30, making it possible to calculate the percentage.

12. Quality of Care: Antidepressant Medication Management

48% of Enrollees 18 years of age and older who were newly diagnosed with and treated for a new episode of major depression remained on antidepressant medication for at least 84 days (12 weeks).

32% of Enrollees 18 years of age and older who were newly diagnosed with and treated for a new episode of major depression remained on an antidepressant medication for at least 180 days (six months).

Numerator and denominator: utilize HEDIS 2009 specifications for the measure "Antidepressant Medication Management"

Data source: claims and enrollment

This indicator is in development.

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
84+ days												
180+ days												
Standard	**48% or more for at least 84 days** **32% or more for at least 180 days**											

13. Quality of Care: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

50% of Enrollees with alcohol or other drug dependence (AOD) initiate treatment through an AOD outpatient assessment (first diagnosis) and receive a follow up treatment service within 14 days of the diagnosis.

75% of Enrollees with alcohol or other drug dependence (AOD), initiate treatment through an AOD outpatient assessment (first diagnosis) and receive a treatment service visits within 30 days of the diagnosis.

Numerator: the number of enrollees with an initial SA assessment paid claim that has follow up treatment(s) within the time parameters indicated above
Denominator: the number of enrollees with an initial SA assessment paid claim

Data source: claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
within 14 days	60.6%	60.3%	62.7%	63.2%	64.2%	62.9%	61.4%	65.3%	64.4%	64.7%		
within 30 days	69.4%	70.6%	73.7%	73.6%	76.1%	73.8%	71.4%	76.3%	75.5%	74.9%		
Contract period to date							Within 14 days: 65.9% Within 30 days: 70.4%					
Standard							**50% or more within 14 days** **75% or more within 30 days**					

Note: a two-month claims lag is required for this report

14. Quality of Care: Outcome Measurement – Medicaid Adults and Older Adolescents

The Contractor shall support Medicaid adult Enrollees such that at least 50% of adults receiving Iowa Plan outpatient services report improvement in emotional health as reported by comparison of initial and most recent assessment using the Consumer Health Inventory (CHI).

Numerator: the total number of Enrollees, age 14 or older, that have at least 2 CHI scores with the most recent during the reporting period, where improvement is shown from the first to the most recent score

Denominator: the total number of Enrollees, age 14 or older, that have at least 2 CHI scores with the most recent during the reporting period.

Data Source: CHI Outcomes Assessment Report

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
%	71.4%	66.7%	57.1%	55.8%	51.9%	46.3%	49.0%	48.0%	63.3%	58.5%	61.0%	57.5%
Standard							**Report aggregate improvement from initial to follow up administration**					
Contract Period to Date							**54.7%**					

15. Quality of Care: PCP Coordination

The Contractor shall measure the frequency with which network providers communicate with PCPs regarding Enrollees whom they are both treating.

Numerator: the number of randomly sampled network treatment records reviewed during the reporting period where communication between the network provider and PCP is documented to have occurred

Denominator: the number of treatment records that were reviewed during the reporting period

Data source: sampled network treatment records

	2010		2011	
	Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**
% of cases w/documentation	84.8%	81.9%	81.9%	70.1%
Standard	**70% or more**			

Note: reported quarterly.

16. Quality of Care: Psychotropic Medication Screening

The Contractor shall identify medication utilization that deviates from current clinical practice guidelines; specifically, the Contractor shall report quarterly and year-to-date instances of three or more drugs in the same class being prescribed per enrollee.

	2010		2011	
	Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**
%	18.4%	16.5%	19.0%	

Note: the data are reported quarterly with a one month lag.

17. Quality of Care: Return to the Community for Children in PMICs

The Contractor shall measure its performance in helping children return to the community by tracking average Iowa Plan Enrollee length of stay in PMICs for mental health services.

Numerator: the number of days of mental health stay in PMICs by Iowa Plan child and adolescent Enrollees

Denominator: the number of Iowa Plan child and adolescent Enrollees with a PMIC mental health stay

Data source: as reported by IME/Medical Services Quarterly

	2010		2011	
	Jul-Sep	**Oct-Dec**	**Jan-Mar**	**Apr-Jun**
Days	257.1	272.4	234.8	248.9

18. Quality of Care: Treatment of the Dually Diagnosed

The Contractor shall increase the percentage of dually diagnosed Enrollees discharged from inpatient substance abuse and mental health treatment settings such that at least 75% of discharged Enrollees receive either a substance abuse or mental health service within 7 days of discharge.

Numerator: dually diagnosed Enrollees discharged from either an inpatient substance abuse or a mental health treatment setting who received either substance abuse or mental health services within 7 days of discharge. Enrollees with both Medicaid and Medicare are excluded.

Denominator: dually diagnosed Enrollees discharged from either an inpatient substance abuse or a mental health treatment setting. Enrollees with both Medicaid and Medicare are excluded

Data source: authorizations and claims

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
%	55.4%	48.6%	52.3%	58.5%	55.5%	61.0%	51.9%	50.0%	49.7%	53.1%		
Contract period to date							53.5%					
Standard							**75% or more within 7 days**					

Note: a two-month claims lag is required for this report.

19. Inpatient Concordance Rate - Initial

The Contractor shall monitor its performance in the rate of concordance with facility requests for inpatient mental health care. This will be for community-based facilities and will not include the state MHIs.

Numerator: the number of initial requests for mental health inpatient treatment that the contractor receives from facilities and authorizes a 24-hour level of care

Denominator: the number of initial requests for mental health inpatient treatment that the contractor receives from facilities

Data source: authorizations

	2010						2011					
	Jul	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
%	95.5%	92.7%	93.7%	94.4%	96.8%	96.9%	95.7%	96.3%	95.6%	94.9%	94.7%	97.0%
Contract period to date							95.3%					